KANSAS CITY
PUBLIC SCHOOLS

CONFIDENTIAL

PRESCRIPTION MEDICATION ADMINISTRATION/DISPERSAL AUTHORIZATION

All prescription medications must be provided in containers with the patient's name, date issued and dosage requirement to act as a physician's directive and therefore will not require a doctor's written authorization. Please note that all medications should be taken home no later than the last day of class to maintain current prescription expirations and dosages.

TO BE COMPLETED BY PARENT/GUARDIAN

Child's Name: ____ Male/Female: ___________

Student ID: __________________ Student's Date of Birth: ______________ Grade: _______

Name of Prescription: ____

Dose: ________________ Time to be given: _________________ Method to be given: ______________

Is child authorized to medicate himself/herself? Yes/No

Date of service start: Month: ________ Year: _________ End Date: Month __________ Year: _____

Special Instructions:

____

____

Name of Prescription: ____

Dose: ________________ Time to be given: _________________ Method to be given: ______________

Is child authorized to medicate himself/herself? Yes/No

Date of service start: Month: ________ Year: _________ End Date: Month __________ Year: _____

Special Instructions:

____

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__________ ________________________ ________________ ________________

Date Parent/Guardian Signature Home Telephone Emergency Number